

NWX HRSA BHPR

Moderator: Shannon Bolon
July 25, 2011
2:41 pm CT

Man: (Unintelligible) requires specialized care from experts in the field.

Man: Welcome and thank you for standing by. All participants do have open lines for the duration of today's conference call. If you need to mute your lines, you may press star 6 to mute and unmute your lines.

Today's conference call is being recorded. If you have any objections you may disconnect at this time. I will now turn the conference over to Miss Shannon Bolon. Ma'am you may begin.

(Bobby Strickland): Good afternoon and welcome everyone. This is actually (Bobby Strickland). Dr. Shannon Bolon will join us in a few moments.

Thank you for joining us on the technical assistance webinar to discuss the performance measures for the Primary Care Residency Expansion program, Residency Training Programs, and the Teaching Health Centers. Again my name is (Bobby Strickland) and I am the Project Officer for the Primary Care Residency Expansion program in the Bureau of Health Professions that I will often refer to as BHPR.

My colleagues in the Bureau that have joined me on this call are Anthony Anyanwu, the Project Officer for Residency Training, Dr. Shannon Bolon, the Branch Chief for the Primary Care Medical Education branch, and Dr. Songhai Barclift, the Branch Chief for the Community-Based Training Branch.

In an effort to provide you with more technical assistance related to your grant programs, the Bureau of Health Professions will host a series of quarterly TA webinars on various topics that will help you manage and implement your grant program project. Today's webinar is the first of a series and we welcome your suggestions on topics that you think we should cover on future webinars.

The purpose of today's webinar is to provide you with information about revised data elements that will inform Bureau-wide performance measures. After we provide you with some initial information, we would like to engage in open dialogue to get your feedback on some key questions.

This call is being recorded and will be available for replay using a toll-free number until August 31 of 2012. I will provide you with that number and passcode at the end of today's call.

By way of background, BHPR's mission is to increase access to health care by developing, distributing, and repainting a diverse, culturally competent health work force. We continuously strive toward fulfillment of this mission through our many grant programs that are awarded throughout the nation to eligible entities.

To ensure that we are good stewards of resources, we use performance measurement to in part gauge the impact of our programs. Performance

measurement indicates what a program is accomplishing and whether results are being achieved and helps to demonstrate the value of Title III, VII, and VIII programs of the Public Health Service Act.

Performance management helps HRSA by providing us information on how resources and efforts could be allocated to ensure effectiveness and it keeps grantees focused on the key goals of a program. It aids in answering questions about our programs from upper management at the Department of Health and Human Services, Congress, and the public.

Data collection and the performance measurement process also support more targeted and rigorous evaluation activities that the Bureau conducts periodically.

Finally, performance measurement supports development and justification of budget requests for these programs by indicating how taxpayers and others benefit. The work you do and the performance measurement data you collect related to the work is crucial in making the case for continuing - continuity of this program.

BHPR has four years of experience with the current performance measures and has identified the need to revise them to more accurately evaluate our successes in four BHPR strategic focus areas: quality, quantity, diversity and distribution in the health professions. In addition the Affordable Care Act reauthorized many of BHPR's programs and the data collected needs to address shifts in programatic emphasis or new program activities.

Finally, BHPR needed to renew the Office of Management and Budgets...

Woman: She would have received from the Program Officer either Tuesday or Thursday, or Wednesday.

(Bobby Strickland): Excuse me, you need to mute your line please.

Woman: (Unintelligible.)

(Bobby Strickland): Operator can you mute all the lines please?

Woman: Sorry, that was a conference call in the background. Can you forward me an email you received from the Program Officer either Tuesday or yesterday.

(Bobby Strickland): Excuse me, can you please mute all lines?

Woman: Yes and so what they are discussing today. That would be great. I'd really appreciate it. Thanks. Bye.

(Bobby Strickland): Excuse me, this is being recorded and your lines are currently open so we can hear you when you are speaking. Please put your phones on mute.

Woman: Sorry about that.

(Bobby Strickland): Finally, BHPR needed to renew the Office of Management and Budget's Paperwork Reduction Act clearance of our performance measures. Some of you may have seen the so-called 60-Day Notice in the Federal Register soliciting comments on the revised measures.

BHPR used this revision process as an opportunity to examine and improve performance measures across BHPR grant programs, covering numerous

performance metrics. Approximately 1500 grantees will use these data elements to make program improvements.

The goal is to collect richer, more meaningful data that will enable us to provide more detailed, descriptive answers to questions about our programs as well as to be more useful in evaluating our programs. In addition, the revision seeks to ensure that all the critical outputs and outcomes that BHPR programs are charged with accomplishing are represented in the data collected at all points in the grantee process including in the application, at award and annually after award.

Over the last several months BHPR staff have been reviewing existing measures and methodologies for measuring program impact, exploring the extent to which development of measures or adaptation of existing measures is appropriate for specific programs.

The revision process has allowed us to identify cross-cutting areas and common performance measures across programs, eliminating data duplication and unnecessary reporting burden for grantees.

Existing logic models, data collections forms, and accompanying guidance including data definitions and descriptions of data sources have been examined and revised as needed to support revised performance measures.

Discussions were held whenever possible with current grantees to involve them in the review and revision process as well.

And as mentioned earlier, we are currently in a formal 60-day comment period intended to make certain that the public and our grantees have an opportunity to comment on the revised measures. This process has resulted in

a set of refined measures, tools and guidance to provide more accurate and programatically relevant data for government performance and results act and other reporting as well as to support evaluation activities.

In addition to continuing the use of aggregated data for most program reporting, individual-level data collections will be an added requirement for grantees in selected program areas, including programs that produce primary care providers and programs designed to increase the diversity of the health work force.

Please note that not all programs will collect individual-level data, and this will be discussed in more detail later in the webinar.

Now that I have covered the background of the performance measures revision process, I would like to talk a little more about - more concretely about what this means for you as a grantee. The performance data revision package will be submitted to the OMB for clearance on July 20, 2011.

Clearance is expected from OMB by November 2011. However, in anticipation of overall approval, we are asking grantees to review the data that will need to be collected and implement any needed changes in their data collection activities beginning as soon as possible.

The first reporting of the revised measures will occur July August 2012. Most of the changes to the performance measures are compatible with existing data collection requirements or will ask for data that most grantees already collect but was not previously requested by us. Therefore we do not anticipate that the burden of data reporting will increase significantly for grantees.

Performance reports will be submitted through the HRSA Electronic Handbook System - EHB. So the mechanism that grantees previously used to submit reports will not change. We do however anticipate providing alternate approaches to submitting the performance data for grantees who wish to take advantage of them. More details will be provided at a future date.

To reiterate, grantees are asked to begin collecting data under the new measures beginning July 1, 2011. The first reporting of the revised measures will occur in July or August 2012 in the HRSA EHB system.

Now I would like to introduce Mr. Anthony Anyanwu, and he will discuss the general tables.

Anthony Anyanwu: Thank you (Bobby). The following (unintelligible) in order to (unintelligible) the Public Health Service Act requirements for data collection. The Public Health Service Title VII, Section 799(c)(2) are to provide a denominator for the measures used to meet the Government Performance and Results Act requirements and the Office of Management and Budget OMB's program assessment and evaluation requirements.

A variation of this table has been used in previous reporting mediums. However there are changes. The instructions have been simplified and revised to accurately account for the number of participants our programs touched.

No double counting is allowed. For the purpose of compiling and analyzing data, anyone who received training or education in a BHPR-funded program is considered a student. For each question, provide the population data requested for the period between July 1, 2011 and June 30, 2012.

Please note - program completors is closed for this year's residents, which should be accounted for in the previous equation. Count each student on your rolls.

In public (unintelligible), it will be based on previous (unintelligible). A version of this table has been used in previous reporting years. Change - the instructions have been simplified. The instructions have been revised to accurately account for the number of participants our programs touched.

No double counting is allowed. For the purpose of compiling and analyzing data, anyone who received training or education in a BHPR-funded program is considered a student.

Provide data on age and gender data between July 1, 2011 and June 30, 2012. And release our students that we are training in BHPR-funded programs and have not graduated or completed programs before June 30, 2012. Count each student on your rolls. Total must equal (unintelligible). Programs providing corresponding individual-level data will be pre-populated.

Why DV1 provide that the (unintelligible) percent of under-represented minority students. DV2 is used to collect the (unintelligible) of disadvantaged students in the BHPR-funded programs. The percent of under-represented minority students in BHPR-funded programs is represented by DV1.

For the purpose of compiling and analyzing data, anyone who receives training or education in a BHPR-funded program is considered a student. Provide the number of students by grades on this listing that have graduated or completed programs between July 1, 2011 and June 30, 2012.

For (unintelligible), provide the number of students who receive training and have not graduated or completed programs before June 30, 2012. Again count each student on your rolls. Please note programs providing corresponding individual-level data will pre-populate.

For the purpose of compiling and analyzing data, anyone who receives training or education in a BHPR-funded program is considered a student. Provide the number of students by grade on this listing that have graduated or completed programs between July 1, 2011 and June 30, 2012.

For (unintelligible) provide the number of students who receive training and have not graduated or completed programs before June 30, 2012. Again, count each student only once. Please note programs providing corresponding individual-level data will pre-populate.

Disadvantaged means an individual who, one, educationally comes from an environment that has inhibited the individual from obtaining knowledge, skills and abilities required to enroll in and graduate from a professional school; or number two, economically comes from a family with a level of income below the level based on low-income threshold according to family size published by the U.S. Bureau of Census, adjusted annually for changes in the consumer price index and adjusted by the Secretary for using all (unintelligible) professional programs.

Note program providing corresponding individual-level data will pre-populate the total number of disadvantaged students. Note rows two and four will be pre-populated for everyone.

We realize that many of you may be concerned about important individual-level data and issues of confidentiality. We also are (unintelligible) that you

may have to make changes in the data collection processes, including informed consent procedures and (unintelligible).

HRSA is fully aware of and sensitive to these issues. And we will work with grantees to ensure that, one, information that you send to us is properly safeguarded; and number two, that you receive any needed technical assistance to help facilitate the process.

We will only be asking for personally identified information in selected programs, where BHPR intends to conduct follow-up and (unintelligible). All other programs will report individual data using grantee-assigned unique identifiers.

They do not identify the individual. Being able to identify specific participants of our program is essential for longitudinal tracking of participants that will help us understand where this individual is. And (unintelligible) professional training programs funded by Title III, VII and VIII grants.

More generally, collecting individual-level data on participants will increase the usefulness of the data for program and position purposes. We are asking all grantees to create a seven-digit numeric unique identifier for all program participants that you will be reporting on. This unique identifier will be used for the same participant through the duration of this grant and should remain consistent in all your reports.

At this point I will hand it on back to Dr. Bolon to proceed with the rest of the webinar.

Shannon Bolon: Thanks Anthony. This is Shannon Bolon, the Primary Care Medical Education Branch Chief. I supervise the administration of the Residency Training and

Primary Care Residency Expansion Programs, among others. Operator, please open the lines for questions at this time.

We will now review the tables. After introducing each table, I will indicate which grantees will complete this specific table. Please refer to the tables labeled Table PC1, Program Level Supply Indicators for Primary Care.

Table PC1 will be completed by Residency Training and Primary Care, Primary Care Residency Expansion, and Teaching Health Centers grantees. The purpose of this table is to obtain information about your program's training capacity and to learn about the current trainees and program completors.

There are three parts to Table PC1, labeled A, B and C. You will complete PC1 A, B and C. Instructions and clarifications follow each table. We will walk through a brief example.

A pediatric residency program that, as part of their grant-related activities, provides training to its residents and faculty would select the following from drop-down menus. First, for Health Profession, they would indicate "Physician." Next, for Primary Program Focus, they would select "Residency Training."

Although this grantee has multiple levels of trainees, the principal purpose of the program in their grant is residency training. For Trainee Level, they would select "Resident," "Faculty Academic," and "Faculty - Community-Based."

The few options for faculty allow (unintelligible) to distinguish between Academic Health Center or Residency Program-Based faculty and Community Preceptors or Community-Based faculty.

The remainder of the fields will be completed for each of the trainee levels. If your degree - or excuse me, if your program does not offer a degree, you would select "None." You only report the number of current trainees and program completors for the reporting period.

For example, if you were completing this table in July of 2011, you would only count the number of trainees and the number who completed the program between July 1, 2010 and June 30, 2011. These dates are consistent with the reporting period.

Are there any questions regarding Table PC1?

(Peter Broderick): This is Peter Broderick. Are you able to hear me?

Shannon Bolon: Yes we are. Go ahead.

(Peter Broderick): Yes. My question really refers back to the previous slide in which we need to develop a unique identifier for each of our residents who are funded. Is there no nomenclature that you want us to follow as far as standards?

Is there any way that the unique identifier could have some consistency across the various THC-funded entities such that, you know, research could be facilitated? Or are these just to be random numbers that we come up with with the very low risk -- but possible risk -- that we would get the same identifiers for more than one resident.

Shannon Bolon: Your suggestions are certainly good. We are going to come back to this issue a little bit later in the TA calls today. And there will be additional guidance that is provided for the individual-level data in the future.

(Peter Broderick): And if I may have a follow-up question? We weren't given any guidance as to whether a full-time equivalent was to be entirely funded by the THC, in which then there would be an individual for whom their entire training is being funded by the THC grant. Or in our case we were the only residency that had all of our residents eligible for THC funding by virtue of being a new residency in July 2010. We actually assigned an FTE percent of training that was in the Teaching Health Center for each resident.

So in some sense, some residencies may actually designate all their residents as being exposed to a Teaching Health Center whereas in other programs that did expansion there will be a hybrid population, some of whom will be THC-funded and some of whom will be funded in the traditional form.

If we are looking for differences in outcome, can the residencies select which residents are THC-funded residents, and if that designation is to stay throughout the three years or could it change from year to year?

Songhai Barclift: Hi (Peter). This is Songhai. I am the - I know (Peter) but just to introduce myself, I am the Branch Chief for the Community-Based Training Branch.

And to answer your question - your program is a little unique, but these are performance measures, so these measures will look at the impact of any student that is touched by the funding.

So in your case, since there are a number of residents that are affected by the funding, even though they are not fully-funded like 100% by THC dollars, you would still report on any resident that is being supported with the funding.

(Peter Broderick): Good. I appreciate that Songhai, because I do think we talked about this in Washington - that it really isn't going to be a difference in treatment between residents that are THC-funded versus those that are not, and the outcomes may not be very different. So I appreciate being able to report on all my resident outcomes.

Songhai Barclift: Correct. Any resident that is affected by the funding. And to answer the other question about the unique identifier - because our program is a little different than the other BHPR-funded programs, we will be coordinating our unique identifiers so that across the board, the data that we collect will all be the same identifier.

But for the purposes of this discussion, the unique ident - you know, we'll just follow the directions. So once it comes to HRSA, we will make sure that we coordinate that with our other unique identifier.

(Peter Broderick): Okay thank you.

Songhai Barclift: You're welcome.

Shannon Bolon: Next question please? Okay, we are going to go on to the next table.

(Ilene Murray): Sorry, this is (Ilene Murray) from Children's Hospital Oakland. I am new to our grant - and I am sorry to interrupt, we had some problem with our mute button.

We are not able to get onto the webinar for some reason. We are having technical difficulties. It says it is not started. Is there a way that you can email the slides to us after this is done because I am not able to follow along with

what you are speaking about and it's been difficult to understand because we can't follow along.

Shannon Bolon: We certainly can email you the slides, but you can also contact (Cindy Eugene) at 301-443-3870 and she can assist you with accessing the webinar.

(Ilene Murray): Repeat that number. 301-443...

Shannon Bolon: 3870.

(Ilene Murray): Thank you.

(Maryann Jonitis): Oh hi. This is (Maryann Jonitis) from Bronx Lebanon. I am having the same problem so I don't know if it is something on your end, because I participated in the webinar earlier this week and there weren't any slides that were coming up.

(Peter Broderick): This is (Peter). I noticed one thing we got an original notice that had a slide H - URL that ended in R-M-P-T-A.

Shannon Bolon: Okay.

(Peter Broderick): Forward slash. And then when - last night we got another email that ended with R-M-P-T-A-1 forward slash. So maybe there is just a difference there because when I clicked on the old link it was getting the same experience that the two other callers had. The rmpta1 forward slash is working.

(Maryann Jonitis): Thank you.

Shannon Bolon: Thank you (Peter). Any questions regarding Table PC1 at this time?

Okay. Please refer to the table labeled Table PCR, Curriculum Content. Table PCR will be completed by Residency Training and Primary Care, Primary Care Residency Expansion, and Teaching Health Centers grantees. The purpose of this table is to obtain information about the innovative or out-of-the-box curriculum content that your program is providing that is beyond the standard curriculum.

These are topics that set your program apart. You will again see that instructions and clarifications precede the table.

The first column lists content areas. You will first decide if the content area is a highlight of your program - then if it is, as part of a required, elective, or both required and elective activity. Then you will indicate if the material is taught through research, traditional didactic or classroom model, or experiential learning. Experiential learning may include clinical work, community or population interventions or outreach, and public health strategies.

The "teaching strategies" located in the first column halfway down refer not to how your faculty teach the content, but what teaching strategies your trainees are being taught to use. Are there any questions regarding Table PCR?

Are there any additional content areas that you would like to have included in this table?

Man: Overwhelmed by...

Shannon Bolon: Okay. If you are uncomfortable sharing your ideas or questions at this time, we will go over your - how to reach out after the technical assistance call and webinars today, and you are welcome to share your thoughts at that time too.

Please refer to the table labeled Table R1, Program Level Supply Indicators for Residency Programs. Table R1 will be completed by Residency Training and Primary Care, Primary Care Residency Expansion, and Teaching Health Centers grantees. The purpose of this table is to provide detailed information about recruitment, retention and placement of trainees.

You will first indicate the Health Profession that is the focus of your program from a drop-down menu. The examples are listed in the far left. Do we have those? Okay.

Those examples of health professions would be for example, Physicians. Then you would indicate the discipline from a drop-down menu. Disciplines describe the primary care specialty - for example, Pediatrics.

A new program did not exist prior to the beginning of the grant project period. The number of positions added during the reporting period are the newly created training positions that will be recruited for -- not the placement of new resident trainees. The number of approved training FTEs, or full-time equivalents, is the number of trainee FTEs that your program is accredited to have.

The number filled is how many of the positions offered were successfully filled with a trainee during the reporting period. Are there any questions about Table R1?

(Peter Broderick): ...again. Sorry to ask so many questions. You know, some of the content is something that we actually know now. When will these data reporting tables be available for us to start populating information, because training is often very busy and if it is all at the end of the year, it will be a little bit overwhelming. Can we start sooner than the end of the grant cycle?

(Cassandra Barnes): Yes you can, and thank you for asking that question. We are in the process of developing a template of and/or providing particular software so you can guys can actually kind of upload your information to us instead of having to manually enter in the digital pieces of information. So that will be available soon and you will receive a notice.

(Peter Broderick): Great. Thank you.

Shannon Bolon: Next question please. Okay we are going to move forward.

Please refer to the table labeled Table EXP1, Experiential Training. The purpose of this table is to obtain detailed information about the experiential learning activities provided by the grantee. Once again, examples of experiential learning may include clinical work, community or population interventions or outreach, and public health strategies.

Table EXP1 differs from Table PCR. Table PCR gathers information about how specific content is taught. Table EXP1 gathers information about the actual experiential training strategies. There are four parts to Table EXP1. Residency Training, PCRE, and THC grantees will only complete EXP1-D. They will not complete A, B or C.

You should report on all experiential training, not just that supported by the BHPR grant. Table EXP1-D as in dog will be completed as I mentioned by all participants on this call.

This table will request information on how much training in four specific training sites: FQHCs or Federally Qualified Health Centers, HPSAs or Health Profession Shortage Areas, MUCs or Medically Under-Served Communities, and Rural Areas. Definitions for these designations will be those standard from HRSA and will be provided to you in the glossary that will accompany the performance report.

Rotations should be blocks of training time. For example, a four-week period when the trainees spend the majority of their time working in this particular location. Are there any questions regarding Table EXP-D?

Okay. Well I will turn it over to Dr. (Cassandra Barnes) who will go over the individual-level data.

(Cassandra Barnes): Good afternoon everyone. Some of the information I am going to talk about is labeled BHPR individual-level data. And this relates to - we talked about this in the introduction of the slides about how the Bureau is looking at changing our practice and really trying to answer a lot of the questions that have been proposed to us by Congress, through (unintelligible), through our headquarters.

Really trying to provide or prove evidence of efficiency and effectiveness of our programs.

And so we realize that we needed more robust information and more data elements to actually be able to do various types of evaluation. And so under

the Affordable Care Act, we have actually been given the mandate to conduct longitudinal studies.

So certain programs are in the first line to do or participate in the longitudinal studies. And so those are the programs that we are starting with to collect individual-level data. Some other programs will collect individual-level data but at a certain - at a lesser intensity until we get ourselves really going with the first kind of pilot group.

And so you guys are fortunate enough to be in our first kind of pilot session to collect longitudinal individual-level data. So we really appreciate any comments and feedback that you have. We know several of you may have experienced the Jefferson Longitudinal Study in the institution and so our individual-level data was somewhat tailored after that study that has been around for several years. So again we look forward to any feedback that you may have for us.

So we will go ahead and get started with what you see on your screen now. And so the information is split into various points in time of when we want to collect the information about each of the individuals or the participants and the trainees in the program.

So at the entry point, again we expect for you guys to create a unique ID -- seven-digit number -- for each of the participants that you will assign to a student and follow that participant throughout their training.

And we would also hope that you keep track of this unique ID number throughout your recordkeeping just in case a student may come back in another three or four years, that they could still maintain that unique ID number.

And we will assure that the unique ID numbers are also connected to your grant unique ID number, so that will reduce any duplications of unique ID numbers from one grantee to the other. But grantees are responsible for creating the unique ID and maintaining that unique ID for that particular student.

So basically at entry point we will get the demographics of the student; their race, gender, ethnicity, basic things that we normally ask for in aggregate form. Here we are also looking at the childhood residence.

And the point of this is to really kind of determine the background of the student. And many times this may be self-reported. But do they consider themselves growing up in an area that was considered rural, or urban, or frontier. And many people may not know whether or not their childhood residency was in a medically under-served area, but we can tell that by looking at the ZIP code.

I know we are open to more discussion about what may be a better way to get that information, but really trying to figure out based on the person's background, if that has any correlation to what they study and whether or not they remain in (unintelligible).

So other things we will ask for at entry point deals with their achievement levels and their latest degree, what their GPA is, MCAT score, GRE score -- which is not there but we will add. And then the unique ID will be again linked to any of the aggregate tables that you provide information to us.

So if you filled out the R1 table about a degree program, then we would be able to link that unique ID number to the aggregate information. So discipline,

degree, their education level, if they are a professional - we need more information about their place of employment to determine if they are currently working in an under-served area or they serve any under-served population.

So now to the annual collection - so this annual reporting - again you would use that same unique ID that would be linked to your particular grant number. And annually for the particular participant you would want to know about their achievement level.

Again this is taken from the Jefferson Longitudinal Study where different pieces of information that we will collect. So for instance a first-year medical student - we want their GPA. A second-year medical student - we would be interested in their GPA but also their (unintelligible) scores, et cetera, et cetera.

And continue to look at what we are going to collect annually. Of course if they receive any financial support from BPHR, we want to know what that amount is and annually whether their status is still full-time or part-time for that. So that works out.

And again if they are professional we would want additionally the information about their place of employment and if they have obtained any board certifications or licenses.

So then that would also be annually - if they have taken part in any clinical experiential training, we would want to know about where they are actually getting trained. So again this is about looking at the experiences of each of the participants.

So we want information on where they are getting trained, the type of setting they are getting trained in, and particularly if they have any - if they are trained in any of the settings that have a federal designation such as MUC or HPSA, if it is a rural or urban area, and if that student was working with any particular under-served population or global population, or if they received any training from any special disciplinary training and their contact hours.

And if they had a mentor or served as a mentor, and any reserves that they contested. And so those are things that we would collect annually about the students' experiences.

And then at the exit point of - either they have (unintelligible) your program, or they graduated, or your grant has ended, then we would want to select particular information about them. So that what we will be able to take that information when we get to their unique ID and be able to follow them in the future. So in another year or three we could conduct a longitudinal study.

So we would have their achievement levels. And we would also like to conduct an exit survey which would ask them about their intent to practice in a primary care setting, under-served community, their intent to serve a particular global population -- things like that. If they choose to pick another degree, certain types of employment -- things like that.

And here is the only time that we would ask for personal identifiable information is at the exit point. Again to be able to link their unique ID to their personal identifiable information so we can find this person in the future.

And of course this would require informed consent from the student. So at the entry point and annually, the unique ID will not have any critical identifiable

information, but then (unintelligible) to maintain the unique ID on an individual.

And then at the exit point we will take the unique ID and link that to the personal identifiable information to be able to follow up with the student.

So does anyone have any questions about individual-level data?

(Peter Broderick): This is (Peter Broderick) again. I am sorry I am so interested in this. There are a couple of thoughts. One, I would also include potentially board certification status. Most all the grads are board-certified, but not everyone. And that would be an important thing.

The other issue I have is at the other end of the educational trajectory, which is when they finish high school. You can gather an awful lot of information about their educational background if you know the high school that they graduated from.

That isn't appearing to be requested at this point, but I suggest that might be something to consider because there is ways of determining whether they came from an educationally disadvantaged environment, with high school graduation rates being publicly available and the percent of grads going on to college being publicly available.

(Cassandra Barnes): Thank you. That is something we hadn't thought about but we will definitely make that note. Any other questions? Anyone else had experience with longitudinal studies and looking at our data, realizing we left anything out, or anything you think - anything that you currently collect that we didn't ask about?

(Travis Sozour): This is (Travis Sozour) from Community. Can you define disadvantaged for me?

(Cassandra Barnes): Yes we - there is a (unintelligible) definition that we have, and it's broken down to - by educationally disadvantaged, economically disadvantaged. And we have those definitions in our current manual that is found online. And of course it will be included in our glossary that we send out to you.

(Travis Sozour): Perfect. Thank you.

(Cassandra Barnes): Is this information feasible to collect? I mean - we are assuming that all of you collect this type of information anyway. Any thoughts? If anyone is talking, we can't hear you so please unmute.

Anybody have any questions about any of the tables - LR1, LR2, DV1, DV2, Residency, Primary Care, Individual? Okay. So we will continue with the presentation.

Of course if you have questions or you would like to make additional comments we are going to provide you with an email address. You are free to take the table and make changes, edits, on the document and email that to us if you like at paperwork - what is it? Anyway - well we will read that off to you in a few minutes.

But we are definitely open to any suggestions and any feedback that you have. And I will turn it back over to Anthony to finish up the call.

Anthony Anyanwu: All right. Thank you (Cassandra). Thank you all for all your feedback. We will take all your comments into consideration as we roll out the revised performance measures. As a reminder, you will be able to access the final

revised reporting guidelines at <http://batr.hrsa.gov/grounds/reporting/index.html>. Once the guidance is finalized, all grantees will receive a notice indicating the document is ready to be viewed.

We expect grantees to begin collecting data as per the revised performance measures beginning July 1, 2011. The first reporting period will be July/August 2012.

As mentioned previously, the (unintelligible) to comment on the performance measure revisions is currently open and will close on July 20, 2011. If you have any comments please send them to paperwork@hrsa.gov.

This webinar has been recorded and can be replayed until July 31, 2012. To access the replay please dial the toll-free number 1-800-679-9654. The passcode is 7423.

We would like to thank you again for your participation on this webinar and for contact information regarding the Project Officers responsible for the programs - for Residency programs you want to contact Anthony Anyanwu, the Project Officer. And the email address is aanyanwu@hrsa.gov.

For Primary Care Residency and Special Programs the Project Officer is (Bobby Strickland). You can reach her at bsstrickland1@hrsa.gov. Training - Teaching Health Center Program Officer is (Kristine Guardino). You can reach her at kguardino@hrsa.gov.

Shannon Bolon: We are being plied a bit for more questions before we sign off.

Woman: Unintelligible.

Shannon Bolon: Oh okay. Well thank you, have a great afternoon. We will look forward to receiving any of your additional comments.

Woman: Thank you.

END